



Behavioral Support Strategies FAQ (updated 12/2022)

Restrictive Measures

Rights Restrictions

Q. *Restitution – a person receiving services understands what money is, how it works, and that damage to items cost money to replace. This person has behaviors that results in damage to other's property and house property – where and what does restitution look like?*

A. If restitution is part of a behavioral strategy (and all of the above is true) the informed consent must be thorough. Meaning that the person is fully aware that at any time they can choose to not pay the restitution. They should be aware of what alternatives there are and what legal sanctions might result, etc. Teams should seriously consider what exactly this means. Historically, we have generally found that most individuals do not realize a person can't 'make them' pay for something they've broken. Often times their financial assessments do not support the understanding of the value of money that the behavioral strategy includes.

Q. *Are GPS devices a restrictive measure?*

A. If there is a paid waiver provider in place and the GPS device is utilized for behavioral purposes and the person is required to wear/use it and Risk of Harm or Likelihood of Legal Sanction is present, the device and its function of monitoring will need to be approved by HRC. If the GPS device is used just to know the location of the person only and the person doesn't mind wearing the device, it would not be considered a restrictive measure.

Q. *How does one person's restrictive measure affect a roommate?*

A. There is not a requirement for a roommate to have a behavior strategy due to the other roommate's actions. There is no need to track or monitor the roommate. If restrictive strategies are put in place, the roommate should have access to any locked items and be able to live freely in their home.

Q. *If Thicket or pureed food is prescribed as a treatment for a medical condition (swallowing disorder) is it considered a rights restriction?*

A. No, a modified diet ordered for a medical condition is not considered treatment for behavioral challenges. Every effort should be made to help support the individual in following their medically necessary prescribed diet. Modified diet textures such as mechanical soft,



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thickened liquids, chopped or pureed are ordered to aid someone in proper swallowing. Not following these diets place an individual at risk for choking, aspiration and even death. If an individual does not wish to follow their prescribed diet, then the team should reconvene to discuss the risks, ensure individual/guardian understand the risk, needed supports and communicate such conversations with the prescribing physician. Often there are supports that can assist the individual with exercising their choices while still following their dietary guidelines. Ultimately, if they person does not want to follow the diet it would be a restrictive measure if they are required to do so. Every effort should be made to prevent this from occurring.

Q. *What if the individual agrees to a restriction within the context of an OhioISP? (If they are requesting the help)*

A. All restriction strategies would need to be approved by HRC along with informed consent from the individual and/or guardian if the reason for the restriction is behavioral.

Q. *What do you do when a guardian wants a restriction that does not meet risk of harm or legal sanction?*

A. Guardians are a member of the team and do not supersede the rule requirements for implementing a restrictive measure. A guardian's decision must meet rule criteria. It is the responsibility of the team and HRC to ensure the rule is followed. It is important for the team to understand the guardian's perspective and work to support the individual as best as possible. If a guardian has a probate court order for a restrictive measure it would need to meet risk of harm or likelihood of legal sanction and be processed in the same manner as other restrictive measures.

Q. *Are alarms, chimes, or bells restrictive?*

A. Alarms, chimes, or bells are not restrictions but it's the action staff take when the alarm goes off that could be a restriction. If a staff person won't let the person leave the room or house, then it is restrictive. If the person is able to continue moving where they want to go, then it's not a restriction. The only time the alarm, chime, or bell would become restrictive in itself is situations where the person does not want it (asks that it be removed, etc....) and the team believes it must be kept due to risk of harm. It would go through all the approval of restrictive measure steps at that point.

Q. *Is 1:1 (or other levels) supervision a restriction?*

A. Supervision is not generally seen as a restriction. Supervision is only a restriction when the person does not want the level of supervision but it is required to be maintained for



behaviors.

Manual Restraint

Q. *Is there a time limit on manual restraint?*

A. Some crisis intervention models do include time limits, but there is no specific limit in the rule. The other guidelines require it to be used only when there is risk of harm. This means that the restraint should cease as soon as risk of harm is no longer met.

Q. *Does blocking, as in blocking someone from self-injurious behavior, constitute physical (manual) restraint or is it only when we place our hands on them that it is considered manual restraint?*

A. Blocking someone from self-injurious behavior is not a manual restraint but there are some things to consider.

- Blocking egress due to behaviors is time out.
- Putting a pillow between the floor or wall and somebody's head would not be restraint (manual or mechanical).
- Putting my forearm up to block when somebody goes to hit me would not be restraint. I should also remove myself from the situation and not put any force toward them with my arm.
- Grabbing their hands to prevent them from hitting their head would be a restraint.
- Grabbing somebody to turn and push them away (a blocking move in one of the common crisis programs) when they are trying to hit you would be a restraint because you put your hands on them. Even if you used a blocking pad to push them away, you're still putting force on them and it would be considered a restraint.

Chemical Restraint

Q. *If medication/sedation is used for dental work, etc., should on-going attempts to try without medication/sedation occur at each annual review or is it sufficient to try one time only? Or should each appointment be a time to try without sedation first?*

A. It is not necessary to try without sedation/medication as long as the method used is a method that would be used for a person with or without a disability. The use of sedation should be individualized and their medical and trauma history considered. The use of sedation should be reviewed with the person's physician/specialist if they have certain medical conditions. For some people waking



up after sedation can also be traumatic. There are several person-centered tools and webinars on the <https://dodd.ohio.gov/about-us/MIID/Trauma-Informed-Care>

Q. *Is there a simple way to determine if a medication is a chemical restraint?*

A. **DODD Chemical Restraint Job Aid**

Q: What if the parent or the person is administering the medications?

A: If the person or an unpaid family member is completely administering the medication without any assistance from the provider, then it would not be considered a chemical restraint. If the parent is paid to provide services, they are a specialized provider and need to follow this rule.

Q: When an individual takes several medications for their various and multiple diagnosis and together those medications cause extreme tiredness - is that considered a restraint?

A: If the person is bluntly suppressed, yes. Each case would need to be evaluated individually.

Q: What criteria should we use to determine if a medication is a chemical restraint or a medication for an illness?

A: Identify the purpose of the medication for the diagnosis. Additional steps will be to monitor how the medication affects the person's ability to complete activities of daily living.

Q: Would it still stand that a medication for a diagnosis in the DSM-5, such as Anxiety that it would not be considered restrictive?

A: The DSM-5 is no longer used to determine if a medication is a chemical restraint. A medication prescribed for the treatment of a physical or psychiatric condition in accordance with the standards of treatment for that condition and not for the purpose of causing a general or non-specific blunt suppression of behavior, is presumed to not be a chemical restraint.

Q: Who is responsible for making sure the scripts are written in ways that align with these rules?

A: Medication administration requires prescriptions be written in such a way that staff are able to understand them and not use judgement. Staff need to be able to demonstrate that they understand how to administer the medications.

A provider should not administer a medication without clear direction and follow up with the physician as needed for clarification.



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Q: Just want to get clarification, is Depo Provera and other types of birth control considered a chemical restraint? What if it is being used to stop woman's menstrual cycle?

A: If you're using it to control menses, or regular birth control, that's, that's the same as anybody else and would not be considered a chemical restraint. If Depo Provera is administered against their will, because they wanted to get pregnant then it would be a chemical restraint

Q: What about someone who has a diagnosis of panic attacks? any medication that would be given for this would calm the person, would that be considered blunt suppression?

A: If the person is still able to complete activities of daily living, then the person is not bluntly suppressed. In such situations, these medications should be seen as supportive. It is understood that some people may need a chemical restraint during these moments of panic.

Q: Sometimes when individuals are hospitalized for psychiatric needs, several medications are changed or added at one time. If blunt suppression is noted in the days following, are there any suggestions regarding how to ensure we don't cause stress to the person by making multiple adjustments to determine which med may be suppressing them?

A: The team should take the 30 days to see if symptoms of blunt suppression continue, follow up with the prescribing physician, and an emergency approval process may be used if it goes beyond 30 days.

Q: So if an individual is prescribed Depo Provera for a diagnosed sexual disorder and they get an injection every 3 weeks as prescribed, would we need to complete an incident report every time the medication is given, even though it is a regularly prescribed medication?

A: This is a chemical restraint. It would be included in the person's plan and processed as a restrictive measure. Incident reports are not required for restrictive measures include in the plan and approved by HRC.

Q: What about medications that are designed to cause somnolence for sleep difficulties?

A: If a person is prescribed a medication to help them sleep, and the desired outcome is sleeping when they are normally sleeping, it's not a chemical restraint.

Q: Back to the Zyrtec example, even if the person's allergies were so bad that it causes the need for Zyrtec to be taken more times in the day than just night, the medication is not being used "for the purpose of causing a general or non-specific blunt suppression of "behavior". Sneezing and watering eyes are physical symptoms. This does not sound like a chemical restraint. Can you clarify using the definition of Chemical Restraint?



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A: In this example, the person is not being bluntly suppressed as they are still able to complete activities of daily living.

Q: How do we prove to someone that the individual's behavior was not bluntly suppressed with a medication whether ordered routinely, prn etc.?

A: Don't assume that you have to prove that there is no blunt suppression for every medication that a person takes. When it occurs, you would see evidence of blunt suppression, such as not being able to complete activities of daily living. This should be evidenced by documentation or incidents (UI's or MUI's).

Q: Who will determine if a med bluntly suppresses someone?

A: Any team member who notices a person is unable to complete activities of daily living and reports via unusual incident or major unusual incident.

Q: How does this differ from the previous rule which restricted the use of PRN chemical restraints?

A: Chemical restraints may occur for medications with either scheduled dosing or PRN that bluntly suppress the person.

Q: So then we might have a chemical restraint after the fact - for instance when a new med prescribed, given, blunt suppression occurs, documented, advise doctors and THEN to the RMN for chemical restraint?

A: Here is the process for reconsideration of a medication initially presumed to not be a chemical restraint:

- The provider is to alert the individual's QIDP or SSA, as applicable.
- The QIDP or the SSA is to ensure the prescriber of the medication and the individual's team are notified.
 - The prescriber of the medication may adjust the medication (type or dose) in an effort to abate the general or non-specific blunt suppression of behavior.
 - When the prescriber of the medication is not inclined to adjust the medication, the individual's team is to meet to consider what actions may be necessary (e.g., seeking an opinion from a different prescriber or introducing activities that may mitigate the impact of the medication on the individual's ability to complete activities of daily living).
- When a medication (as originally administered or as adjusted) continues to cause a general or non-specific blunt suppression of behavior beyond thirty calendar days, the medication is to be regarded as a chemical restraint and processed as a restrictive measure.



Q: It is beginning to sound like we are assessing "all" medications vs. those that are prescribed for the purpose of causing a general or non-specific blunt suppression of behavior. People can have medications for medical conditions i.e. cancer, arthritis, seizures, etc. that may cause drowsiness, etc. but are subscribed to treat medical/physical symptoms. I don't think Teams or HRCs have the medical training to assess and/or that it would be appropriate for HRC to approve or not approve in these situations.

A: The rule is not intended to interfere with relationship between the doctor and patient, nor to second guess the practice of medicine. Rather the requirements of the rule aim to ensure that:

- there is an overall service plan for the person that provides person centered supports in addition to medication.
- the person's response to the medication is mainly centered on the signs and symptoms of the condition for which it is prescribed.

Assessing all medications and a person's response to them should always occur. If a person is bluntly suppressed (cannot complete daily activities of life) now teams should have further discussions concerning whether or not the medication is a chemical restraint.

It is understood that at times chemical restraints are necessary.

Informed Consent

Q. *Can consent be given for only the OhioISP but NOT the behavior support strategies in the plan?*

A. No, the OhioISP and behavior support strategies are not separate plans. If there are team members who dissent to a part of the OhioISP, the team needs to reconvene and come to agreement on what strategies are acceptable and which strategies will be removed. The planning process is a team-oriented function that requires agreement from all involved parties, including the person. Please remember that restrictive strategies require informed consent.

Q: *Is the informed consent going to have a separate signature section or does the signature page cover all aspects within the OhioISP?*

A: The informed consent page in the OhioISP is for restrictive measures.

Human Rights Committee

Q. *What are the guidelines around a balanced HRC?*



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A. Along with having at least 4 members (one person eligible for services and one person with experience in behavior support practices), the Committee must have equal representation between County Board reps, ICF reps, provider reps, or other DD professionals and individuals eligible for services, their family members, or guardians. Participation in the meetings should be consistent. Ex. If the individual eligible for services has missed 3 of the last 6 meetings the Committee would not be balanced. It is permissible to have alternates for the different roles as long as balance is maintained at the meetings.

Q. *Who needs to be trained as members of the Human Rights Committee?*

A. All members of the HRC need to be trained. Reasonable accommodations should be made if necessary.

Q. *Is there a minimum number of training hours for HRC members? Can it be combined?*

A. There is no stated number of training hours. There is a specific initial training available on the DODD website. There are webinars on the DODD website for annual trainings. A county board or ICF can submit training for potential approval provider.certification@dodd.ohio.gov

Q. *Where can the HRC trainings be found at?*

A. The HRC trainings can be found at:
<https://dodd.ohio.gov/about-us/BehavioralSupportStrategies/Learning+and+Resources>

Q. *Can there be more than one HRC committee in a facility?*

A. Yes, the requirement is to have an HRC in the facility and county board, but how those are created and implemented is up to the organization.

Q. *Does the SSA/QIDP turn in the entire OhioISP for review to the HRC or just the behavior portion?*

A. Each HRC will need to decide how much information they would like to see in order to make an informed decision about the proposed restrictive measure(s).

Q. *The required 90-day review that is in rule, how is this review done? Does it have to be a formal team meeting or can it be done in other ways?*

A. The 90-day review can be done in a manner that best fits the team. It does not have to be formal or be reviewed by the HRC.

Q: *How many DSP's need to be involved in the 90-day review process when a manual restraint is used?*

A: At least one DSP that was involved in a manual restraint for that person.



Youth

Q. *Does a county board operated school follow the requirements of the rule?*

A. Each county board administration that has a school program will make their own determination as to whether their school shall follow 5123:2-2-06 along with applicable Ohio Department of Education requirements. If they choose to have their school(s) follow the rule their policies and procedures should reflect that.

Q. *What does age appropriateness look like for youth?*

A. Rule 5123:2-2-06 is based on the premise of upholding the rights of individuals with developmental disabilities as enumerated in Section 5123.62 of the Revised Code. Section 5123.62 provides safeguards for people with disabilities to ensure they are not treated differently than people with no diagnosed disability. It is understood that citizens obtain many rights upon becoming an adult at the chronological age of 18.

A county board of developmental Disabilities (CB) or an Intermediate Care Facility (ICF) may choose to develop practices for those under the age of 18 based on age appropriateness, that is practices that are often used for any child whether the child has a disability or not. If a CB or ICF decides to permit age-appropriate practices, the CB or ICF must develop a policy that includes the following:

- Specify what restrictions will be permitted and under what circumstances they can be used.
- Describe the approval process for these practices which may include the Human Rights Committee (HRC) or an alternate approval process.
- Direct how these alternative practices will be developed by the team and included in the individual's plan.
- Recognize that the prohibited measures in the behavioral support rule are also prohibited for minors.

Examples (not an inclusive list) of restrictions considered age-appropriate:

- The use of a timeout chair for children under 8 for a limited time.
- Time limits on the use of electronic devices for those under 18.
- No access to sugary snacks right before a meal for those under 10.
- Requirements for the completion of homework or chores before play time for those under 13.



Examples of procedures for approving restrictions considered age-appropriate:

- Person-centered plan team approval of a developed list of restrictions.
- ICF Administrator or CB Service and Support Administration Director approval of specific restrictions.
- Team and HRC Chairperson approval of specified restrictions.

Assessment

Q. *Does someone have to be approved by DODD to complete an assessment? (in regard to bachelor's or graduate with 3 years paid experience)*

A. DODD does not approve who can conduct assessments.

Q. *In instances in which there is a Behavior Support Specialist position within the county board or ICF, could that individual perform some of the SSA/QIDP responsibilities (i.e. secure consent, etc.) or does it have to be the SSA/QIDP?*

A. This is up to each county board or ICF. There is nothing in the rule that prevents this option.

Q. *What are some acceptable ways to prove/document that a risk of harm is direct and serious?*

A. Through already established practices such as the UIR, doc sheets, case notes, MUI process, Discovery, medical records, counseling assessments/notes, and etc. DODD is not prescriptive in the type of assessment.

Restrictive Measure Notification Application

Q. *For the projected Expiration Date of restrictive measures, would this typically be one year after implementation if a shorter time period is not delineated in the plan?*

A. Yes. The approval cannot be longer than one year. A shorter time frame is permissible.

Q. *When should you submit an RMN?*

A. RMNs for the person are completed at the initial implementation of the restrictive measure, as well as any revision, provider plan changes, and annual renewal of the restrictive measure.



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Q. *Is it required to update the RMN when a restrictive measure is discontinued?*

A. Yes. The RMN should be "Discontinued" in the application when it is no longer being used.

Q. *Does a certain person at the county board have to complete the RMN?*

A. No. Although someone from the county board must submit the RMN, the county board may determine which of its staff submits the RMN to DODD. The same is true for ICFs.

Q. *Does the team have to wait to implement the restrictive strategies in the plan until DODD approves the RMN?*

A. The submission of the RMN is not an approval process. The final approval of a restriction is the local Human Rights Committee. However the RMN is to be submitted prior to implementation.